STATEMENT BY
REPRESENTATIVE DAVID P. ROE, M.D.
BEFORE THE SUBCOMMITTEE ON HEALTH
HOUSE ENERGY & COMMERCE COMMITTEE
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Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, thank you for inviting me to testify today. I applaud the subcommitteeôs efforts to shine a light on the danger posed to seniors by the Independent Payment Advisory Board, better known as IPAB.

Created as part of the Democratic health care law that went into effect last year, the IPAB is charged with developing proposals to ñreduce the per capita rate of growth in Medicare spending.ò Certainly, something must be done to ensure that this important program remains available not only for current retirees, but for the next generation as well. The Medicare Trustees recently projected that the Medicare trust fund will go bankrupt in 2024. The Congressional Budget Office says the fund will be exhausted even sooner, in 2020.

We already know what President Obamaôs plan to ñsaveò Medicare isð $500 billion in cuts to the program and the IPAB. The cuts speak for themselves, but the American people deserve to hear the truth about the IPAB, as it is little more than a roadmap to rationing.

Now, some say that PPACA expressly prohibits rationing, raising revenues or beneficiary premiums, increased cost sharing, or other restrictions on benefits. This is highly misleading, as nothing in the law prohibits cutting payments to physicians. Already, Medicare only pays physicians between 85 and 90 cents on the dollar, which has made it difficult for beneficiaries to access the care that they need. If reimbursement falls even further, it could very well become economically impossible for physicians to see Medicare patients. With millions of baby boomers becoming eligible for Medicare, IPABôs cuts couldnôt come at a worse time.

The IPAB will also adversely impact the quality of patient care. For an example, look no further than Britainôs National Institute for Health and Clinical Excellence, or NICE. Last year, NICE rejected the use of Avastin for treating patients with bowel cancer because it was considered too costly. Decisions regarding patient care shouldnôt be made by a panel of 15 unelected bureaucrats who havenôt examined the specifics of an individualôs unique case. Medicine is not a one-size-fits-all disciplineð what is effective for treating one patient may be harmful if applied to another. By centralizing medical decision making, the IPAB would put a Washington bureaucrat squarely between patients and the care recommended by their doctor.

In addition to degrading access to and quality of care, IPAB has two significant structural problemsð it is both unaccountable and unworkable. The board is empowered to make recommendations regarding Medicare without any input from the Congress. Donôt just take my word for it ï former OMB Director Peter Orszag has called IPAB the ñsingle biggest yielding of power to an independent entity since the creation of the Federal Reserve.ò

Even after the IPAB makes its recommendations, the hands of the legislature are still tied. The proposal would be considered under ñfast-trackò procedures and, without a three-fifths vote of the Senate, Congress can only modify the type of cuts, not their size. And if Congress fails to act on the boardôs recommendations, they automatically go into effect. This isnôt government by the people; it is instead government by the technocrats.

Questions have also been raised regarding the IPABôs ability to function as it is designed. In reference to the IPAB, CMS chief actuary Richard Foster wrote in an April 2010 memo that ñlimiting cost growth [per beneficiary] to a level below medical price inflation alone would represent an exceedingly difficult challenge.ò CBO, on the other hand, projects no savings

resulting from the IPAB over the next 10 years. In both cases, these expert analyses suggest that IPAB will not yield the results promised by its proponents.

Further, the legislators who created the IPAB made clear that they want this board to impact more than just Medicare. PPACA requires the IPAB to make recommendations about how to restrain private sector health care cost growth as well. While these recommendations do not automatically go into effect, they will no doubt serve to encourage private insurance companies to cut provider payments. Ultimately, cuts to private insurance provider payments will result in even less access for Medicare beneficiaries because most providers shift costs onto private insurance to make up for Medicare losses. So everyone loses under this scenario.

While it seems that there is little that our two parties can agree on in the current environment, both sides have acknowledged that the IPAB is a terrible idea. Thatôs why my bill to repeal the IPABð the Medicare Decisions Accountability Actð has more than 155 bipartisan cosponsors. The American Medical Association has endorsed my legislation, as did a broad coalition of more than 270 health care-related organizations. Even former Democratic Leader Dick Gephardt has called for the IPABôs repeal.

Mr. Chairman, itôs time that we begin a fact-based conversation about reforming Medicare without the demagoguery that has marked recent months. I canôt think of a better place to start than a bipartisan effort to repeal the IPAB.